



COVID-19 Considerations in the Urgent Care Clinic

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COVID-19 (SARS-CoV-2) has swept the country and world in rapid and unprecedented fashion. While much of the news coverage and scientific studies have focused on hospital needs and demands, as well as patient care in hospital settings, urgent care (UC) clinics remain on the frontlines, too. In fact, many UC clinics are seeing an increase in demand from patients with COVID-19 symptoms.

Additional patient volume increases may come from changes in operations at other medical settings such as primary care clinics and outpatient specialty clinics, many of whom have changed to telemedicine or closed their doors for patients with respiratory symptoms or entirely. As a result, it is important that UC clinics have clear processes in place to manage patients in this new and ever-changing environment.

Consider the following:

- **Patient flow and physical distancing.** SARS-CoV-2 is believed to be transmitted primarily by droplets.¹ As such, immediate identification followed by isolation of possible COVID-19 patients is of utmost priority. The waiting room of a UC clinic can be very full with patients near each other. As such, if possible, immediately room a patient with possible COVID-19 symptoms into an exam room. If space or operations do not allow that, consider separating the waiting room chairs with 6 feet distance between patients. Another option is to place spots on the floor to identify where patients should stand while in line waiting to check in. Encourage all visitors to wait in the car in order to minimize extra people in the clinic. Limit pediatric patients to only one adult to accompany them.
- **Personal protective equipment (PPE) usage.** The use of

PPE and recommendations for it have been variable and changing rapidly in response to growing information about the illness and its spread. Additionally, there are supply limitations which may affect many decisions. It is believed that the coronavirus causing COVID-19 is spread in multiple methods including droplet, airborne, contact, fecal-oral² and possibly fomite transmission. As such, protection against all forms of transmission is important in keeping staff healthy, especially in high-risk encounters. Patient-facing staff should wear a surgical mask at all times and consider eye protection. Staff who will be in close proximity to the patient and examining the patient should additionally wear gloves and a gown. Lastly, N95 masks are thought to be more protective and should be used when possible, and in particular when performing an aerosolizing procedure (nasal wash/swab, throat swab, suction, nebulizer treatments, etc.)³ Additionally, having symptomatic patients wear a surgical mask is important as this minimizes spread.

- **Clinical evaluation of patients.** While many people infected with COVID-19 are asymptomatic, these are unlikely to present to a UC clinic. One common exception is that many employers have requested that their employee be evaluated and obtain a "return to work" note indicating that they are asymptomatic. COVID-19 can present with a variety of signs and symptoms.⁴ These include fever, conjunctivitis, loss of smell (anosmia), loss of taste (dysgeusia), sore throat, cough, shortness of breath, chest pain, abdominal pain, nausea, vomiting and diarrhea. Cases may be mild, moderate, or severe in nature.



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In the UC clinic, especially during this time of limited resources, it is important to identify those who are experiencing severe COVID-19 infection. Most commonly, this is an evaluation of respiratory status as a result of the viral pneumonia from infection. Tachypnea, hypoxia at rest, and hypoxia with ambulation are very important clinical indicators of severe disease. If

indicated, a chest x-ray (CXR) can help identify pneumonia. Additionally, chest pain is a common complaint in patients with COVID-19 and may reflect associated cardiac injury.⁵ Evaluation using an EKG (and troponin, if available) can be utilized when clinically indicated.

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If a patient is determined to have mild or moderate illness, they can likely be discharged home with education on self-care, symptom monitoring, and home quarantine. Discontinuation of quarantine may occur when the patient has experienced 72 hours without fevers (without use of antipyretics), complete resolution of respiratory symptoms (cough and shortness of breath), and at

least 7 days have passed since the symptoms began.⁶

It is important to advise patients that the illness commonly lasts up to 14 days (and occasionally more). It appears that if the patient is going to progress to severe illness, this occurs around days 7–10 after symptom onset. However, if the patient presents with severe illness, transport to the nearest emergency department for further evaluation and treatment is indicated.

An initial work-up in the UC clinic should include a CXR, predominantly. While abnormalities can often be detected with complete blood count (CBC), basic metabolic panel, liver function testing (LFT), d-dimer, ferritin, lactate dehydrogenase (LDH), procalcitonin (PCT), troponin, and viral studies (influenza, RSV, etc.), the prognostic value of any of these tests in COVID-19, if abnormal, remains highly uncertain and, therefore, they are generally not indicated in ambulatory patients.

■ **COVID-19 testing.** Access to testing has been limited by many factors, including the development of the test itself in the United States, testing supplies including nasal and oropharyngeal swabs and viral media, and laboratory ability to perform the test. Initially, all tests were performed at

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the Centers for Disease Control and Prevention, and from there spread to state public health departments and finally to private and hospital laboratories. While the capacity to test has improved, there are still limitations in this area. At this time, testing is still largely reserved for patients with severe disease who are hospitalized, as well as high-risk patients (age >65, heart disease, immunocompromised, diabetes, chronic lung disease, chronic kidney disease, etc.), however, this is changing rapidly. It is recommended that you work with your local laboratory and state public health department to determine capacity and resources.

While testing for patients with mild symptoms is limited, they should be presumed positive and advised to self-quarantine until symptoms resolve as discussed above. As the point-of-care, CLIA-waived PCR test becomes more widely available, criteria for who can be tested will appropriately expand.⁷

- **Extra cleaning and disinfectant processes.** There are mounting data that COVID-19 can live on various surfaces for a period of time. It is unclear if it remains infective during that time. However, ensuring that the UC clinic remains clean is exceptionally important. Additional measure should be taken to wipe high-contact surfaces (check-in counters, workstations, etc.) throughout the day. Rooms and equipment used on patients (vital sign machines, otoscopes, handles on doors and cabinets, etc.) should be wiped after each patient use.
- **Contingency planning.** It is important that contingency planning begin for UC clinics. Various situations and scenarios should be included in the contingency plan. This should include plans for managing increased patient volume and decreased staff availability due to illness. Clinics should increase oxygen supply and equipment for the administration of oxygen. Clinics should implement plans for caring for patients for an extended period of time if Emergency Medical Services are delayed in arriving for a patient call.
- **Diagnosis codes and billing.** ICD-10 codes have been updated to include multiple diagnoses related to COVID-19. Common diagnoses include Exposure to COVID-19 Virus (Z20.828), Suspected COVID-19 Viral Infection (R68.89), and COVID-19 Virus Infection (U07.1). Level-of-visit billing in the UC clinic may continue using regular E/M coding; however, specific COVID-19 circumstances may result in different billing. The American Medical Association has published some guidance for these circumstances.⁸ Please note that the Centers for Medicare and Medicaid Services has relaxed deadlines for reporting to let physicians and their staff focus on the clinical management of COVID-19 patients.⁹
- **Staff support.** This is an incredibly trying time. There are

additional concerns for staff working the frontlines, especially regarding their safety and that of their family members, which poses significant mental health effects.¹⁰ This involves all staff members in the clinic, including clerical staff, medical support staff (medical assistants and nurses), providers, and additional staff (cleaning crews, laboratory staff, etc.). One approach to this is to reduce as many of the unknowns as possible in the clinical setting. Clear, consistent communication, potentially in a forum such as a daily (socially distanced) huddle, can help address this. Reassuring staff that they already have much of the knowledge and skills necessary to address COVID-19 illness (as they can manage other infectious conditions such as measles, influenza, *C diff*, etc.) can serve as a powerful reminder. It is also imperative that UC clinics find ways to support their staff and provide them with additional resources. Options include employee assistance programs, community organizations, state committee/boards, and local hospital/university resources.

COVID-19 will be with us for an undetermined and likely prolonged period of time. Having UC processes in place for the management of this pandemic will facilitate patient care and keep your staff as healthy as possible. During this time, stay safe. ■

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